LOCAL HEALTH JURISDICTION

PLAN AND BUDGET GUIDANCE

PUBLIC HEALTH PREPAREDNESS & RESPONSE TO BIOTERRORISM

JULY 1, 2002 - JUNE 30, 2003

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
PREVENTION SERVICES

EMERGENCY PREPAREDNESS OFFICE

AUGUST 2002

Local Health Jurisdiction Plan and Budget Guidance
Public Health Preparedness & Response to Bioterrorism
Table of Contents

I. INTRODUCTION

A. STATEMENT OF PURPOSE

The California Department of Health Services (CDHS) announces the availability of Fiscal Year 2002-03 funds for local health jurisdictions in California to strengthen their preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. The purpose of this Guidance is to assist local health departments (LHDs) in the development of their local bioterrorism preparedness plans and budgets, both of which are required in CDHS' application to the Centers for Disease Control and Prevention. CDHS is responsible for issuing this Guidance (and future program letters as necessary), receiving and approving local plans, and for providing technical assistance and consultation. In preparing its plan and budget, each LHD should demonstrate how it will use these new funds to:

(1) Build on existing communicable disease surveillance and epidemiologic activities;

(2) Participate with CDHS in all aspects of preparedness planning and, in particular, those areas concerning development of the State's Laboratory Response Network (LRN) and its Rapid Health Electronic Alert, Communication and Training System (RHEACTS); and

(3) Integrate local planning efforts with other local and regional resources, such as those available from the Metropolitan Medical Response System (MMRS) cities and the Governor's Office of Emergency Services' (OES') Mutual Aid Regions, which exist to provide regional support of local government.

B. LEGISLATIVE AUTHORITY

In response to the heightened threat of bioterrorism, Congress authorized funding through the Public Health and Social Services Emergency Fund (Section 319 of the Public Health Service Act, 42 U.S.C. 247[d]) to support activities related to countering potential biological threats to the civilian population. This funding is being provided under the Department of Defense and Emergency Supplemental Appropriations for Recovery from and Response to Terrorist Attacks on the United States Act, 2002 (Public Law 107-117). In authorizing these funds, the federal government intends for state health agencies to establish and implement a strong infrastructure -- in collaboration with LHDs, hospitals and other health care providers, and local/regional emergency medical service agencies -- to ensure immediate and adequate response to any acts or threats of bioterrorism, infectious disease outbreaks, and other public health threats or emergencies. On April 15, 2002, CDHS submitted an application to receive funds for bioterrorism preparedness and response to the Centers for Disease Control and Prevention (CDC). That application was subsequently approved in June 2002.

Sections 101315 through 101319 are being proposed as additions to the Health and Safety Code. These sections would make the federal funding received by CDHS for bioterrorism preparedness and emergency response subject to appropriation in the annual Budget Act. They also would provide for the appropriation of LHD awards.[1]

C. EMERGENCY PREPAREDNESS/RESPONSE AUTHORITY IN CDHS

[1] State Fiscal Year 2002 Trailer Bill, Assembly Bill 442.

The September 11, 2001 attacks on the World Trade Center and the Pentagon, coupled with the October, 2001 anthrax mailings, present an unprecedented challenge to governmental entities at the federal, state, and local levels. As the lead public health agency in California, CDHS has an important responsibility to prevent, mitigate, investigate, and respond to bioterrorist events, should they occur in our state. CDHS responds to incidents of bioterrorism through the Emergency Preparedness Office (EPO), but many other essential departmental resources from the laboratories, disease surveillance and epidemiology, environmental health, licensing and certification of health facilities, and health communications also are involved.

The EPO is also the formal operational state agency link representing public health with the Governor's Office of Emergency Services (OES). Under the authority of the Emergency Services Act and other State legislation, OES is the lead agency within State government responsible for mitigating, planning, preparing for and responding to, and aiding in the recovery from the effects of all types of emergencies that threaten lives, property and the environment. Through the Terrorism Annex of the *State of California Emergency Plan*, the Emergency Medical Services Authority (EMSA) is charged with coordinating medical operations during a terrorist event. CDHS is likewise charged with coordinating public health operations and with several important technical functions: environmental assessment and monitoring; chemical/biological/radiation exposure control; protective response; recovery and re-entry; drinking water protection; and food supply protection.[2]

II. GENERAL INFORMATION

A. LHD FUNDING INFORMATION: FISCAL YEARS 2001-02 and 2002-03

From its appropriation from CDC, CDHS has made three categories of funding available to eligible LHDs in California:

Category 1 Funding in FY 2001-02

An initial award was made available via a contract to each eligible LHD for immediate use for two purposes: (1) to develop a local Bioterrorism Preparedness Plan and Budget, due October 15, 2002 (the initial due date was September 15, 2002), and (2) to cover a portion of the LHD's urgent costs, as described in the following paragraph. This funding was allocated using the formula described in Section 101315, proposed as Trailer Bill Language that would add new provisions to the Health and Safety Code.

Upon execution of the contract, funds could be used for planning and to cover urgent costs associated with bioterrorism response efforts that were incurred as a result of the events of September 11, 2001 or in response to the national anthrax events. Unless CDHS is notified, only 10 percent of Category 1 Funding may be used to cover urgent costs. Furthermore, these urgent costs must have been incurred in the period between September 11, 2001 and February 19, 2002. The urgent costs claimed must be allowable under the terms of CDHS' initial agreement with CDC, e.g., preparedness planning and assessment activities; epidemiologic investigations; enhanced laboratory security and testing of samples; increased health alert activities.

Category 2 Funding (FY 2002-03)

[2] Office of Emergency Services. *State of California Emergency Plan, Terrorism Annex.* Lead Agencies for Emergency Response.

These funds are being distributed to LHDs using the formula-based methodology and will be disbursed via formal agreements. An Application, Plan and Budget are required to release the initial quarterly payment. Subsequent payments are conditional, based upon receipt of a signed Agreement and accepted written Progress and Expenditure Reports that describe activities, progress toward achieving critical capacities and benchmarks, and document the appropriate use of funds. Efforts associated with the use of these funds must adhere to the CDHS' application to CDC.

Category 3 Funding (FY 2002-03)

This category of funding is only available to LHDs that maintain either a Level A or Level B Public Health Laboratory. These funds are not part of the formula-based allocation to LHDs and eligible laboratories must meet a separate set of activities that support California's development of the Laboratory Response Network (LRN). The activities will be included in the agreements that CDHS writes with each LHD. A portion of the planning activities must be described as part of the Plan submitted to CDHS on October 15, 2002. The requirements for funding of the Level A and Level B Public Health Laboratories are included in this Guidance as Appendix 2.

Special Provisions

Three LHDs in Los Angeles County are ineligible to receive funds from CDHS: Los Angeles County, Long Beach City and Pasadena City health jurisdictions. The proposed Trailer Bill, described earlier, would allow an eligible health jurisdiction to enter into a contract with CDHS for CDHS to administer all or a portion of the moneys allocated to the LHD. LHDs intending to contract back should contact the EPO. Where appropriate and mutually agreeable, CDHS encourages regional approaches to meeting the conditions of the critical capacities and benchmarks.

B. PLAN AND BUDGET SUBMISSION INFORMATION

LHDs must submit an Application together with a Plan and Budget on or before October 15, 2002. The Plan and Budget must describe activities and account for the full amount of funding for the period of September 11, 2001 through June 30, 2003 by submitting the following documents:

Submission #1: The LHD Category 1 Report -- accounting for urgent costs associated with the events of September 11, 2001, and local bioterrorism preparedness planning activities.

Submission #2: The LHD Category 2 and 3 Plan -- using the required formats described herein.

Submission #3: The LHD Category 2 and 3 Budgets by Focus Area-- using the required formats and accounting for carryover of Category 1 funds.

Submission #4: A Completed Public Health Preparedness and Response Capacity Inventory – Local Version (dated August 2002) – a rapid self-assessment describing the LHDs capacity status.

Submission #5: A Signed Certification Form – attesting to the proper use of the funds in FY 2002-03.
An original and seven (7) copies of these materials must be submitted in hard copy formats. Electronic submission will be accepted; however, if electronic means is used, then all original

signature pages with seven (7) copies of each page must be submitted by mail. Only one copy of the Capacity Inventory (# 4) need be submitted whether submitting by mail or electronic means. Submission by facsimile (fax) will not be accepted for any of the submissions.

Submissions should be directed to:

California Department of Health Services
Emergency Preparedness Office
601 North 7th Street, MS 244
PO Box 942732
Sacramento, CA 94234-7320
Attn: Kim DeWeese e-mail: kdeweese@dhs.ca.gov

Materials must be postmarked or received by e-mail on or before Tuesday, October 15, 2002. LHDs unable to meet this deadline due to the schedule of their County Board of Supervisors may request an extension by contacting Kim DeWeese, EPO, at (916) 324-7804.

C. REVIEW PROCESS

This is a non-competitive application process. There is a critical need to protect California communities from the threat and act of bioterrorism. All LHDs are encouraged to apply. Each LHD application, plan and budget will be reviewed internally by technical experts within CDHS – e.g., the EPO, Disease Investigations and Surveillance Branch, Immunizations Branch, Division of Environmental and Occupational Disease Control, Laboratory Science, Microbial Diseases Laboratory, Viral and Rickettsial Laboratory, County Health Services, Information Technology Systems Division, Office of Public Affairs, and other administrative and health education staff – and may also be reviewed by representatives of other State agencies, Region IX and MMRS cities.

Review criteria will include how well the plan provides evidence of meeting or progressing toward the CDC objectives, designation of key LHD staff, development of a clear management structure to carry out proposed activities and a budget that supports those activities.

D. TENTATIVE TIMELINES

Please note that the following timeline is subject to change, depending upon further directives from CDC, enactment of the Budget Act, and staff availability.

Description	***Date***
Guideline Released	August 14, 2002
Application, Plan and Budget Submitted	October 15, 2002
Plan and Budget Approved	October - November 2002
Agreements Finalized	December 31, 2002
Initial Progress and Expenditure Reports	March 14, 2003
Annual Report and Expenditure Reports	August 15, 2003
Final Report and Reconciliation of FY 2002-03 Expenditures	November 1, 2003

E. ADDITIONAL INFORMATION

Business management information may be obtained from Kim DeWeese, EPO, at (916) 324-7804 (Email: kdeweese@dhs.ca.gov). The CDHS Focus Area Leads below will coordinate technical information:

CDHS Technical Consultant Listing

Focus Area	*Focus Area Leads*	*Email Address*
A	Kelvin Yamada	kyamada@dhs.ca.gov
B	Sandra Huang Duc Vugia	shuang@dhs.ca.gov dvugia@dhs.ca.gov
C	Paul Duffey John Michael Janda	pduffey@dhs.ca.gov jjanda@dhs.ca.gov
E	Peter Abbott Bob Hall	pabbott@dhs.ca.gov bhall@dhs.ca.gov
F	Ken August Pat Felten	kaugust@dhs.ca.gov pfelten@dhs.ca.gov
G	Richard Sun	rsun@dhs.ca.gov

III. SUBMISSION #1: THE LHD CATEGORY 1 REPORT

Each LHD Plan and Budget will be built on available FY 2002-03 funds. Since FY 2001-02 funds can be carried over into FY 2002-03, it is necessary for LHDs to first describe activities and expenditures, including urgent costs, that occurred in FY 2001-02 and second, to identify the amount of unexpended funds being carried over in FY 2002-03.

A. NARRATIVE REPORT

In two pages or less ***briefly*** describe your jurisdiction's start-up efforts and initial planning activities that were accomplished during the period of February 19, 2002 through June 30, 2002. Include in your narrative how the LHD's post-September 11, 2001/anthrax urgent response costs were identified and submit an itemized list of these costs with your Expenditure Report.

B. EXPENDITURE REPORT

Use the Expenditure Report Form I-1 to display your Category 1 funds and expenditures. Unexpended amounts may be carried over into Category 2 Funding. Please identify the level of carryover funding being requested. If carryover is requested, you must certify that you will not be charging any additional costs against your FY 2001-02 Contract by completing Expenditure Report Form I-2.

Again, the expenditures for the period of September 11, 2001 through February 19, 2002 must have been of an urgent nature and associated with **bioterrorism response** efforts incurred as a

result of the events of September 11, 2001 or in response to the national anthrax events. The urgent costs claimed must be allowable under the terms of CDHS' initial agreement with CDC -- i.e., activities that would be associated with Focus Area A, B, C, D and E. Risk communication and education and training were not part of the initial agreement.

The requested reimbursement for these urgent costs should be **unbudgeted costs incurred by the LHD**, such as staff overtime associated with bioterrorism response efforts, additional or replacement laboratory reagents/materials for anthrax testing, extra printing costs for anthrax brochures, or public meetings. Examples of allowable urgent response costs under the initial CDC agreement are limited to preparedness planning and assessment activities; epidemiologic investigations; enhanced laboratory security and testing of samples; and increased health alert activities (e.g., establishing a web site or phone bank).

C. REQUIRED FORMS

Copies of the Expenditure Report Form I-1 and the Contractor Release Form I-2 are included on the following pages.

EXPENDITURE REPORT FORM I-1

COUNTY _____

EXPENDITURE REPORT
PUBLIC HEALTH PREPAREDNESS AND RESPONSE TO BIOTERRORISM
FY 2001-02 (SEPTEMBER 11, 2001 THROUGH JUNE 30, 2002)

CATEGORY 1 FUNDS

I.	**ALLOCATION AMOUNT**		$
II.	**EXPENDITURE BY COST CATEGORIES**	**A. AMOUNT EXPENDED** [On planning from 2/19/02 to 6/30/02]	**B. AMOUNT EXPENDED** [On urgent costs from 9/11/01 to 2/19/02]
	A) Personnel	$	$
	B) Fringe Benefits	$	$
	C) Travel	$	$
	D) Equipment	$	$
	E) Operating Expenses & Supplies	$	$
	F) Consultants	$	$
	G) Contractual	$	$
	H) Other	$	$
	Total Direct Charges	$	$
	I) Indirect Charges	$	$
	TOTAL AMOUNT EXPENDED (SUM OF CATEGORIES A-I)	$	$
III.	**CARRYOVER TO FISCAL YEAR 2002-03 (ITEM I minus [II A+B])**		$

EXPENDITURE REPORT FORM I-2
CONTRACTOR'S RELEASE
PUBLIC HEALTH PREPAREDNESS AND
RESPONSE TO BIOTERRORISM EXPENDITURE REPORT
FY 2001-02 (SEPTEMBER 11, 2001 THROUGH JUNE 30, 2002)
CATEGORY 1 FUNDS

_____

(County/City and Name of Local Health Department)

The above-named local health department intends to either:

(1) close its FY 2001-02 contract issued by CDHS. Pursuant to the terms of its contract entered into between CDHS and the Contractor identified below, the Contractor acknowledges that payments have been made in the amount of $_____ between the dates of _____and _____ OR (2) decline the contract in full.

By signing this form, the Contractor does hereby release and discharge the State, its officers, agents and employees of and from any liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

By signing this form, the Contractor acknowledges that any expenses claimed for reimbursement does not guarantee final allowability of said expenses. Contractor agrees that the amount of any sustained audit exceptions resulting from any subsequent audit made after payments were released will be refunded to the State.

Contractors Legal Name:
Signature of Contractor or Official Designee:
Printed Name/Title of Person Signing:
Date:

If you are carrying over FY 2001-02 funds please return the original signed Contractor's Release Form with your LHD Category 1 Report. This Report must accompany your FY 2002-03 Plan and Budget and be submitted to:

California Department Health Services
Emergency Preparedness Office
Attn: LHD Allocation Award Program
601 North 7th Street, MS 244
P.O. Box 942732
Sacramento, CA 94234-7320

IV. SUBMISSION #2: THE CATEGORY 2 and 3 LHD BIOTERRORISM PREPAREDNESS PLAN: NARRATIVE REQUIREMENTS

A. ORGANIZATION OF THE PLAN

The components of the Local Bioterrorism Preparedness Plan (termed the Comprehensive, Strategic Local Bioterrorism Preparedness Plan in the FY 2001-02 contract) are listed below. The Plan should be single-spaced, with the pages consecutively numbered beginning with and including the Cover Page.

1. Cover Page

2. Budget Summary Allocations and Proposed Amounts (Plan and Budget Form II-1)

3. Plan Content

   Category 2 Funds*

Focus Area A	Plan Benchmarks 1, 2, 3, 4, 5, 6 and 7 Budget and Justification Narrative
Focus Area B	Plan Benchmarks 8 and 9 Budget and Justification Narrative
Focus Area E	Plan Benchmarks 11 and 12 Budget and Justification Narrative
Focus Area F	Plan Benchmark 13 Budget and Justification Narrative
Focus Area G	Plan Benchmark 14 Budget and Justification Narrative

   Category 3 Biologic Laboratory (if applicable)

Focus Area C	Plan Benchmark 10 Budget and Justification Narrative

4. Organizational Chart/Narrative for LHD Bioterrorism Program

5. Supplemental Materials

* From your Category 1 Form I-1, amounts included as Category 2 Funds may include unspent funds from FY 2001-02 for which you are requesting carryover into FY 2002-03. Use Plan and Budget Forms II-2 through II-7 for Focus Areas A, B, E, F, G and C.

B. PLAN INSTRUCTIONS

Cover Page

The Cover Page for the Comprehensive, Strategic Local Bioterrorism Preparedness Plan must include the name of the county/city, the name of the contact person for the plan, the mailing address of the contact person, the phone number of the contact person, the fax number of the contact person, and an email address for the contact.

Budget Summary Allocations and Proposed Amounts

This page is a worksheet (Plan and Budget Form II-1). It will allow you to calculate your total budget, the suggested amount approved by CDC for your County/City, and the amount you are actually proposing to budget in each Focus Area. CDHS expects these local priorities may change as you complete in-depth assessments, hire staff and begin implementing activities.

Plan Content: Category 2 Funding (Focus Areas A, B, E, F, and G)

Please follow the Category 1 Report and Category 2 and 3 Plan Instructions.

Plan Content: Category 3 Funding (if applicable) (Focus Area C -- Biologic Laboratory Capacity)

These plans require a specific budget and set of activities which will be included in the LHD Agreements. Please follow the Template Instructions to complete your narrative. Please review the LRN Level A or LRN Level B Work Statements in Appendix 2 to develop your Focus Area C Budget. LRN Level B budgets have already been individually negotiated but should be submitted using the cost categories listed in the Focus Area C Budget.

Organizational Chart/Narrative for LHD Bioterrorism Activities

Please include an agency organizational chart clearly identifying how the LHD will organize its Bioterrorism Preparedness Program within the LHD. The Organizational Chart should be accompanied by a one-page description of your management plan for carrying out the proposed work within the LHD or with other county agencies with any responsibilities across the Focus Areas.

Supplemental Materials

Supplemental materials beyond those specifically requested are discouraged and should be limited to brief duty statements for key positions or memoranda of commitment from proposed contractors, if any.

C. LOCAL BIOTERRORISM PREPAREDNESS PLAN TEMPLATE

CDHS is making bioterrorism preparedness funding available to eligible LHDs for the period of July 1, 2002 through June 30, 2003, based on the Critical Capacities and Critical Benchmarks developed by CDC. Six Focus Areas contain 16 Critical Capacities and one Enhanced Capacity if all funding categories are included. The Local Bioterrorism Preparedness Plan must demonstrate how each Critical Capacity or the Enhanced Capacity for which you are receiving funding will be (or is being) met. As the Plan will be formulated based on incomplete information and initiated with

new funding, CDHS considers this plan as a **preliminary** preparedness plan. LHDs will be required to update their October 15, 2002 plans in concert with their progress and full assessment information at the time the first Progress Report is due.

Definition of Terms

Critical Capacities are the core expertise and infrastructure to enable the public health system to prepare for and respond to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies. Each LHD must address all of the critical capacities in its respective Plan and Budget.

Critical Benchmarks constitute activities LHDs should have underway at the time they submit a plan and budget. These activities should be summarized in one-page documents as part of the application.

Enhanced Capacities are the additional expertise and infrastructure over and above the critical capacities that enable public health systems to have optimal capacities to respond to bioterrorism. The only enhanced critical capacities CDHS included in its application to CDC, developed by the State-local working group in Focus Area B, were those enhanced capacities listed in Focus Area B, Area IB. LHDs will be encouraged, but not required, to submit work plans addressing this enhanced capacity.

Plan Template Instructions

A Plan and Budget (see next Section VI) must be developed for each Focus Area for which your jurisdiction is eligible for funding. Each Critical Capacity within the Focus Area must be addressed by your narrative. It is not necessary to prepare a separate narrative for each numbered item listed beneath the Critical Capacity, but these points should be included in your overall narrative for that capacity. If specific information is requested in subcategories, please supply that information as part of your narrative. Unless otherwise indicated in bold, for each Critical Capacity, please provide.

(1) A brief description of the current capacity in your jurisdiction

(2) An assessment of whether the current capacity is adequate; and

(3) If inadequate, a proposal for effecting improvements within the budget period, including major activities and timelines, who will carry out the proposed activities (if known) and whether activities will be contracted.

Start each Focus Area section on a new page. There is no page limitation for the narrative discussion for each capacity but three pages are suggested. The narrative should follow the Template provided in below. The Critical Benchmarks should be prepared on a separate page from the Critical Capacity narrative and are limited to one page each. There is no page limitation on the Budget or Budget Narrative. When addressing a capacity, please retype only the Roman numeral heading and the critical capacity itself. *For example:*

Type:

II. Preparedness and Response Planning

A. CRITICAL CAPACITY: to respond to emergencies caused by bioterrorism, other Infectious disease outbreaks, and other public health threats and emergencies through the development and exercise of a comprehensive public health emergency and preparedness plan.

[Add a narrative that addresses the Critical Capacity above and includes points 1-6]
[Add a one-page timeline for Critical Benchmark #5]
[Add a one-page timeline for Critical Benchmark #6]

Please follow the Focus Area activities in the order listed below to develop your Narrative Plan. Your Budget and Budget Narrative should address all capacities in the Focus Area. Include the Budget information at the end of each Focus Area section.

FOCUS AREA A: LOCAL PREPAREDNESS PLANNING AND READINESS ASSESSMENT

I. Strategic Direction, Coordination, and Assessment

A. Critical Capacity – Establish a process for strategic leadership, direction, coordination, and assessment of activities to ensure local readiness, interagency collaboration, and preparedness for bioterrorism, infectious disease outbreaks and other public health threats and emergencies.

1. Designate a senior local public health official responsible for directing local bioterrorism preparedness and response planning efforts.

Identify the senior local public health official and briefly describe his/her qualifications. If this person is not selected, please describe your approach/timeline for designating him or her.

(Critical Benchmark #1): **Documentation for this benchmark is a brief (less than one-page) description of the duties/qualifications of the senior health official.**

2. Establish a local advisory committee including representatives from the local health department, law enforcement agencies, fire departments, emergency rescue workers, occupational health workers, health care providers, community health centers, volunteer organizations, hospitals, emergency medical services, offices of emergency services, and emergency management agencies.

Describe the advisory committee membership, its organization, frequency of meetings, and charge in terms of interagency collaboration and preparedness for bioterrorism. Include a listing of the participating local groups in the Supplemental Materials Section of the Plan. Provide information on how the committee is or will be staffed. If this is an existing committee, describe the LHDs current role and responsibility on the committee.

(*Critical Benchmark #2):* Documentation of this benchmark is a one-page narrative including a description of an existing committee (e.g., the name, next meeting date, and goal(s) OR a description of the LHDs approach to and goals for convening such a group.

3. Establish a system to provide regular updates about local preparedness activities to the CDHS and to local policy makers and elected officials. A local website covering local preparedness activities may be considered.

4. Establish a coordinated and integrated process for monitoring local progress, allocating local resources, and developing local work plans.
   - Develop tool to monitor progress.
   - Develop, integrate, and update electronic accounting systems.
   - Coordinate with other affected local agencies in developing work plans.

5. Sponsor local conferences and workshops for all local partners and stakeholders including healthcare providers such as clinics, medical groups, the local medical society, etc.

6. Involve parts of the public health system that are not directly involved in bioterrorism preparedness.
   - Involve mental health and social service providers by including them in planning and implementing cooperative agreement activities.
   - Develop and maintain distribution lists that include those public health partners that are not directly involved in bioterrorism.

7. Provide technical, managerial, and leadership training to project leaders to ensure competency.

B. Critical Capacity – Conduct integrated assessments of public health system capacities related to bioterrorism, other infectious disease outbreaks, and public health threats and emergencies to aid and improve planning, coordination, and implementation.

1. Identify implementation priorities by preparing a timeline for assessing emergency preparedness and response capabilities related to bioterrorism, other infectious disease outbreaks and public health threats and emergencies.

   CDC has provided a *Public Health Preparedness and Response Capacity Inventory* (August 2002 version). CDHS will require submission of a completed inventory as a part of the LHD's Plan and Budget. An electronic version of the *Inventory* is located at: http://www.dhs.ca.gov/epo. This inventory may be used alone or as a supplement to other proposed assessments.

   Describe the results of assessments or the above *Inventory* that have been initiated with existing data of your public health system's emergency preparedness and response capacities related to bioterrorism, infectious disease outbreaks or public health threats. Indicate if further assessments of emergency preparedness and response are planned.

   ***(Critical Benchmark #3):* Documentation for this benchmark is a one-page timeline for the LHD's approach to completing proposed assessment.**

2. Prepare a timeline for assessing ordinances that provide local delegation authority for executing emergency public health measures as well as special provisions for the liability of healthcare personnel in coordination with adjacent local jurisdictions.

(Critical Benchmark #4): **Documentation for this benchmark is submission of a one-page timeline for the LHD's approach to assessing its knowledge of state statutes, local ordinances and internal LHD policies.**

3. When assessing ordinances and emergency preparedness and response capabilities, ensure that the response status of the local public health system can be determined.

II. Preparedness and Response Planning

A. Critical Capacity – Develop and exercise a comprehensive public health emergency preparedness and response plan for emergencies caused by bioterrorism, other infectious disease outbreaks, public health threats and emergencies.

1. Prepare a timeline for development of a local plan to respond to bioterrorism, other infectious disease outbreaks, public health threats and emergencies which will include emergency mutual aid agreements and/or compacts and provide for regular exercises that test their joint response proficiency.

(Critical Benchmark #5): **Documentation for this benchmark is a one-page timeline that identifies implementation steps and key activities for development of a local response plan.**

2. Prepare a timeline to work with adjacent jurisdictions and the Regional Disaster Medical/Health Coordinator to develop joint/regional plans to respond to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

(Critical Benchmark #6): **Documentation of this benchmark is a one-page timeline that identifies implementation steps and key activities needed to develop regional plans.**

3. Designate a senior local public health professional responsible for developing and implementing local bioterrorism planning activities.

4. In collaboration with federal, state and other local agencies, assess readiness of local hospitals, emergency medical services, and other components of the healthcare system to respond to bioterrorism, other outbreaks of infectious disease, public health threats and emergencies and include them in local plan development and exercises.

5. Establish and maintain a system for 24/7 notification or activation of the public health emergency response system.

6. Test preparedness and response plan at least annually to demonstrate proficiency in responding to bioterrorism, other infectious disease outbreaks, public health threats and emergencies.

B. Critical Capacity – Ensure that local preparedness for and response to bioterrorism, and other infectious disease outbreaks, public health threats and emergencies are effectively coordinated with State response assets.

1. Develop an interim plan, working with the CDHS, that identifies local personnel to be trained in receiving and managing the distribution of items, such as antibiotics, vaccines, and medical materiel from the National Pharmaceutical Stockpile.

   ***(Critical Benchmark #7): Documentation* of this benchmark is the name of the LHD individual, if known, who will work with CDHS on developing an interim plan for NPS planning. Indicate timelines for identifying local personnel/staff that will need training.**

2. Ensure that all preparedness and response planning is in compliance with the Standardized Emergency Management System (SEMS) and coordinated within the existing emergency management infrastructure as described in the operational area and state emergency plans.

3. Participate in regional exercises conducted by State and/or federal agencies.

III. National Pharmaceutical Stockpile Preparedness

A. Critical Capacity – Plan for the receipt, management, and distribution of the CDC National Pharmaceutical Stockpile, should deployment of the stockpile be necessary in the local jurisdiction.

1. Coordinate with the State Department of Health Services, which is responsible for development of the statewide plan, to receive and manage the National Pharmaceutical Stockpile (NPS), in development of a compatible plan for the jurisdiction to receive and manage items from the NPS. The local plan should include procedures for the mass distribution of antibiotics, vaccines, and medical materiel. The plan should also identify personnel to be trained for these functions, or gaps in available staff or other resources, which will need to be supported by regional, state of federal response assets.

2. Prepare a local description, with integrated local and regional area components, for the management and use of the NPS.

3. Prepare a timeline to obtain documented commitments from all local agencies, organizations and others identified in the plan.

4. Provide basic orientation, training, and periodic readiness exercises for those individuals or entities that will have a role in the NPS management and distribution.

5. At the request of CDHS, develop a plan that includes the establishment of local clinical sites to dispense antibiotics and vaccine during an emergency involving a disease outbreak.

<u>CDHS ACTIVITIES:</u>

Provide consultation on components of assessment and planning and plan development; facilitate sharing of assessment information among LHDs.

Facilitate transfer of information through teleconferences and/or in-person meetings.

Share information and analysis of State laws concerning public health emergency powers.

Support leadership training by developing a new "Public Health" SEMS-type training tied to the State CDHS Terrorism Response Plan.

Provide guidance on regional response plans, planning for and conducting exercises of response plans. These might include response standards, mutual aid templates, and joint training plans.

Facilitate local NPS planning, CDHS will hold monthly in-person and teleconference meetings.

Collaboratively develop strategies for smallpox planning.

FOCUS AREA B: SURVEILLANCE AND EPIDEMIOLOGY CAPACITY

I. Public Health Surveillance and Detection Capacities

A. Critical Capacity – Rapidly detect a terrorist event through a highly functioning, mandatory reportable disease surveillance system, as evidenced by ongoing timely and complete reporting by providers and laboratories within the local jurisdiction, especially of illnesses and conditions possibly resulting from bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

1. Prepare a timeline for developing, implementing, and testing a system to receive and evaluate urgent disease reports from within the local health jurisdiction on a 24-hour per day, 7-day per week basis. Coordinate and update contact numbers for this system with the State and other counties.

   ***(Critical Benchmark #8): Documentation* for this benchmark is a one-page timeline of proposed activities.**

2. Ensure the timely (24/7) ability to transmit disease reports from local health department to the State of California.

3. Ensure that legal authority is in place at the local level that allows investigation of suspected cases, potential terrorist events, or unusual illness clusters.

4. Routinely assess the timeliness and completeness of the local reportable disease surveillance system especially for naturally occurring illnesses and conditions that may mimic those resulting from a terrorist action.
5. Provide ongoing disease surveillance and epidemiology training for local public health, clinical and healthcare staff to develop subject matter expertise at the local level.

6. Evaluate and improve the timely and complete reporting of outbreaks of illness and/or key categories of reportable diseases such as influenza, invasive bacterial diseases, vaccine preventable diseases, vectorborne diseases, and food- and waterborne diseases from the local level to the State.

7. Assess and improve local capacities, including surveillance systems, associated with monitoring dermatological conditions and rash illnesses.

B. Enhanced Capacity (optional) – Rapidly detect and monitor bioterrorist events, other infectious disease outbreaks, or other public health threats by accessing potentially relevant data sources outside the health department by developing new active or sentinel surveillance activities.

Examples of data sources that may be evaluated for their usefulness include data kept by poison control centers, 911 systems, emergency responders, pharmacies, medical examiners, animal control agencies, and veterinarians. Examples of active or sentinel surveillance activities include (i) rapid detection of influenza-like illness; (ii) monitoring of health care utilization indicators such as emergency department visits, hospital admissions, hospital beds occupied, and intensive care unit admissions; and (iii) surveillance for meningitis, encephalitis, or unexplained critical illnesses or deaths.

1. Coordinate and update any enhanced surveillance activity for bioterrorism, infectious disease outbreaks, or other public health threats with the State.

This is an optional activity. LHDs are encouraged to explore the utility of other data not currently used for surveillance and to develop and evaluate new active or sentinel surveillance activities. If funds are being requested for this option activity, please describe the activity, a timeline for activities, and how this new information will be integrated with the LHD's existing infectious disease surveillance activities.

II. Public Health Epidemiologic Investigation and Response Capacities

A. Critical Capacity – Rapidly and effectively investigate and respond to a potential terrorist event as evidenced by a comprehensive and exercised epidemiologic response plan that addresses surge capacity, delivery of mass prophylaxis and immunizations, and pre-event development of a specific epidemiologic investigation and response needs.

1. Assess current local health department epidemiologic capacity and prepare a timeline for achieving adequate capacity.

***(Critical Benchmark #9): Documentation* of this benchmark is a one-page timeline for carrying out an assessment and initial steps to improve LHD capacity.**

2. Ensure that a full-time epidemiological response coordinator for bioterrorism, and other infectious disease outbreaks, public health threats and emergencies has been appropriately designated within the local health department.

3. Coordinate epidemiologic response planning with the overall planning conducted in Focus Area A.

4. Coordinate epidemiologic response planning with hospital preparedness activities being facilitated by HRSA.

5. Train designated local public health staff who would respond to a bioterrorist event in their roles and in the specifics of the local plan.

6. Ensure the performance of risk and vulnerability assessments of food and water to include assessments of production, processing, and/or distribution facilities, if within the local agency jurisdiction and responsibility.

B. Critical Capacity – Rapidly and effectively investigate and respond to a potential terrorist event, as evidenced by ongoing effective local response to naturally occurring individual cases of urgent public health importance, outbreaks of disease, and emergency public health interventions such as emergency chemoprophylaxis or immunization activities.

1. Achieve 24/7 capacity for immediate response to reports of urgent cases, outbreaks, or other public health emergencies.

2. Assess the adequacy of local public health response to outbreaks of disease and other public health emergencies.

3. Assess and strengthen links with animal surveillance systems and the animal health community.

<u>CDHS Activities:</u>

Assess statewide surveillance for priority threat agents, infectious disease outbreaks, and other key categories of reportable diseases, and work with LHDs on strategies to improve the timeliness and completeness of reporting.

Collaborate with LHD staff to develop and conduct trainings on bioterrorism recognition and epidemiologic investigation of outbreaks and urgent disease reports.

Develop the California Electronic Laboratory Disease Alert and Reporting (CELDAR) system in coordination with potential reporting groups (including the animal health community) and public health data users.

Coordinate information received from enhanced surveillance systems implemented by LHDs and provide technical consultation for proposed and existing local enhanced surveillance projects. Support and coordinate LHD field epidemiologic investigations of public health emergencies due to bioterrorism, infectious disease outbreaks, or chemical, radiological, or toxin releases Work with LHD epidemiologic response personnel to assess the adequacy of State and local public health response to such events.

Facilitate dissemination of CDC and CDHS standards for integration of health information and surveillance systems, including specifications for data elements, common user interfaces for CDC/CDHS-supported systems, shared information architecture and software components.

FOCUS AREA E: HEALTH ALERT NETWORK/COMMUNICATIONS AND INFORMATION TECHNOLOGY

A. Critical Capacity – Ensure effective communications connectivity between the local public health department, the CDHS, healthcare organizations, law enforcement organizations, public officials, and others as evidenced by: a) continuous high-speed connectivity to the internet, b) routine use of e-mail for notification of alerts and other critical communications, and c) a directory of public health participants, their roles, and contact information.

1. Prepare a timeline for a plan that ensures that 90 percent of the population in the jurisdiction is covered by the Health Alert Network.

   (Critical Benchmark #11: **Documentation of this benchmark is a one-page timeline of proposed activities.**

2. Prepare a timeline for the development of a communications system that provides a 24/7 flow of critical health information among hospital emergency departments, state and local health officials, public health laboratories, and law enforcement officials.

   (Critical Benchmark #12): Documentation **of this benchmark is a one-page timeline of proposed activities.**

3. Assess and inventory your existing communication connectivity at the local level in relation to CDC's IT Function and Specifications Standards.

4. Describe how directories of local partners and health alert recipients are maintained and updated.

5. Identify and provide contact information on the following roles within your jurisdiction.

B. Critical Capacity – Ensure a method of emergency communication for participants in public health emergency response that is fully redundant with e-mail.

1. Assess local redundant communication device capacities.

   - Assess and improve two-way radios, cell phones, voice mailboxes, satellite phones, or wireless messaging capacities.
   - Assess and improve broadcast and/or AutoDial functions to automatically distribute alerts and messages to the communication devices.
   - Assess and improve the capacity to link to emergency communication systems of state and local emergency response partners.

2. Routinely assess the timeliness and completeness of the local redundant capacities to reach participants in public health response.

C. Critical Capacity – Ensure the ongoing protection of critical data and information systems and capabilities for continuity of operations.

1. Assess and improve the existing local policies and procedures for protecting and granting access to secure systems for the management of secure information, system backup and system redundancy.

2. Perform regular independent validation and verification of Internet security, vulnerability assessment, and security and continuity of operations practices and rapidly implement recommended remedial activities.

D. Critical Capacity – Ensure secure electronic exchange of clinical, laboratory, environmental, and other public health information in standard formats between the computer systems of public health partners. Achieve this capacity according to the relevant IT Functions and Specifications.

1. Assess and propose improvements to the existing capacity at the local level to exchange electronic data in compliance with public health information and data elements exchange standards, vocabularies, and specifications as referenced in the National Electronic Disease Surveillance System (NEDSS) initiative.

2. Ensure that the technical infrastructure exists to exchange a variety of data types, including possible cases, possible contacts, specimen information, environmental sample information, lab results, facilities, and possible threat information.

3. Regularly confirm the successful transmission and receipt of information to and from public health partners.

Note: All local alert and communication system development under Focus Area E must either use the CDHS RHEACTS or use applications that interface and are compatible with RHEACTS and the CDC Public Health Information Technology Functions and Specifications for Emergency Preparedness and Bioterrorism: http://www.bt.cdc.gov/Planning/CoopAgreementAward/CDC9ITFunctionsandSpecifications-last-2-8-02.asp

CDHS Activities:

CDHS will utilize portions of its CDC Bioterrorism preparedness funding to secure contract expert consultation and assessment resources to assist local health department in meeting the critical capacities of Focus Area E. Your plan narrative may provide that you intend to utilize these consultant services to undertake a planning and training assessment that will assist you to:

- Develop a Role-Based Public Health Directory
- Determine their Local Jurisdiction Communications Infrastructure
- Identify Training Needs
- Effectively Utilize Communications Protocols
- Apply Role-Based Structure and Protocols to the Application (Security)
- Determine the Cost for Infrastructure Improvements (Cost Model)
- Document Business Requirements

These consultant services can cover alert and communications systems, electronic reporting and data exchange (ELR and NEDSS), and electronic training systems. In addition CDHS will be developing additional tools and standards that may be utilized by LHDs in meeting the requirements of critical capacities.

FOCUS AREA F: RISK COMMUNICATION AND HEALTH INFORMATION DISSEMINATION (PUBLIC INFORMATION AND COMMUNICATION)

A. Critical Capacity – Provide needed health/risk information to the public and key partners during a terrorism event by establishing critical baseline information about the current communication needs and barriers within individual communities, and identifying effective channels of communication for reaching the general public and special populations during public health threats and emergencies.

1. Develop an interim plan for risk communication and information dissemination at the local level to educate the public about exposure risks and effective public response.

   (Critical Benchmark #13): **Documentation for this benchmark is a one-page description of the LHD existing risk communication duties, including the LHD staff that currently have major responsibilities for risk communication during a disease outbreak.**

2. Conduct a needs assessment to evaluate the communication and information needs for health and risk information for public health threats and emergencies at the local level.

3. Review appropriate risk communication strategies and resources from the private sector, the media, and state and federal emergency management sources, including the CDC Public Health Preparedness and Response Web site, other national Web sites, state and local Health Alert Networks, online and hard-copy "bulletin boards," hotlines and clearinghouses, and other tested communication strategies and concepts.

4. Develop a plan and implement effective channels of communication at the local level to reach the general public and special populations during public health emergencies.

5. Identify local key public health spokespersons and ensure their competency, awareness, and ongoing training necessary to effectively and accurately deliver public health emergency information especially in times of crisis.

<u>CDHS Activities:</u>

Take the lead in working with LHDs to develop a single, low technology risk communication system in California.

Partner in the conduct of formative research/evaluation of communication strategies.

Link LHDs to risk communications information made available from CDC, including model communication plans, guidelines, templates, press kits, and other pre-tested communication resources for guidance, use or customization by local public health officials.

Provide updates on federal and state legislation and policies/procedures impacting the use and release of information.

FOCUS AREA G: EDUCATION AND TRAINING

A. Critical Capacity – Ensure the delivery of appropriate education and training to key public health professionals, infectious disease specialists, emergency department personnel, and other healthcare providers in preparedness for and response to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

1. Prepare a timeline to assess training needs at the local level with special emphasis on emergency department personnel, infectious disease specialists, public health staff, and other health care providers.

   ***(Critical Benchmark #14**):* **Documentation for this benchmark is a one-page timeline that describes the LHD's approach to identify LHD staff and external partners who may need training.**

2. Assess and improve the existing capacity to conduct a training needs assessment and planning for public health and private professionals, and to provide access to training in bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

3. Develop an ongoing plan to meet local training needs through multiple sources.
   - Coordinate with schools of public health and medicine, academic health centers, and CDC training networks.
   - Develop formal partnerships with schools of public health and medicine, other academic institutions, and other organizations that provide education/training.

4. Develop the capacity at the local level to facilitate or provide education and training sessions and services on bioterrorism, and other infectious disease outbreaks, public health threats and emergencies.
   - Provide a trained distance learning coordinator within the LHD.
   - Access to distance learning capabilities (e.g., receive satellite broadcasts).
   - Provide for a higher level of internet connectivity with video and imaging capacity to view live feeds.

5. Review training program content and curricula to ensure educational value.

   - Develop and provide training for a speakers' bureau.
   - Provide training in core public health skills to program staff.
   - Provide funding for critical program staff to attend training, including travel and registration fees.

<u>CDHS Activities</u>:

Facilitate the provision of bioterrorism and competency-based core skills training and continuing education based on needs identified through the state/local training assessments.

Develop a core public health bioterrorism-training program for use or adaptation by LHDs.

Facilitate the transfer of information via notices on workshops, conferences, satellite broadcasts and other means.

CATEGORY 3 FUNDING FOCUS AREA C – BIOLOGIC LABORATORY CAPACITY
(COMPLETE ONLY IF THE LHD IS ELIGIBLE FOR FUNDING)

Category 3 Funding is only open to LHDs that maintain a Laboratory Response Network (LRN)-designated Level A or Level B Public Health Laboratory (PHL). Each LHD receiving laboratory funding for Focus Area C must submit a narrative plan addressing the Critical Capacities and Critical Benchmark, following the template format below. The Laboratory Work Statement, developed by CDHS and approved by CDC, has been included as LRN Laboratory Appendix 2. This Work Statement will be incorporated into the Agreements CDHS writes with LHDs.

FOCUS AREA C: LABORATORY CAPACITY – BIOLOGIC AGENTS

A. Critical Capacity – Develop and implement a local program to ensure rapid and effective laboratory services in support of the response to bioterrorism, and other infectious disease outbreaks, public health threats and emergencies.

1. Prepare a timeline for the development of a plan to improve working relationships and communication between Level A (clinical) laboratories and Level B/C Laboratory Response Network Laboratories to ensure that the Level A laboratories maintain core capability to: (a) perform rule-out testing on critical BT agents; (b) safely package and handle specimens; and (c) refer to higher level laboratories for further testing.

NOTE: Since LRN Level A PHL funding was made available with the express purpose of addressing the critical need for Public Health Microbiologists, the narrative for this Critical Capacity should include how the LHD will address this training need, as well as the other points in LRN Laboratory Appendix 2.

Critical Benchmark #10: **For Level A PHLs, documentation of this Benchmark is a one-page timeline for development of the plan, including developing communication, training, and working relationships with Level A (clinical) laboratories in the jurisdiction (or for Imperial County, across the border) – as well as coordination with the Level B PHL.**

For LRN Level B PHLs, documentation of this Benchmark is a one-page timeline for development of a plan to improve communications and working relationships between the Level A (clinical) laboratories, the Level A PHLs and the Level B PHL. In particular, activities should be proposed that will ensure compliance with reporting requirements, coordination with multi-jurisdictional training plans for Level A laboratories, and adherence to CDHS Level C State Laboratory and the CDC LRN-approved Level A testing procedures.

B. Critical Capacity – For local health jurisdictions with a public health laboratory, as a member of the Laboratory Response Network (LRN), ensure adequate and secure laboratory facilities, reagents, and equipment to rapidly detect and correctly identify biological agents likely to be used in a bioterrorist incident.

LRN Level A PHLs should identify the staff who will be responsible for participating with the assigned Level B PHL and CDHS staff to develop an integrated local

response plan that is coordinated with other local emergency response efforts and with local clinical laboratories. LRN Level A PHLs are responsible for developing operational plans and for providing local training for labs and others on how to collect, process, and transport blood and urine samples to CDC, or a CDC supported laboratory, for analysis of chemical agents. Plans will be consistent with CDC supplied protocols. Level B Laboratories will support and coordinate this activity, but it is a responsibility of the Level A PHLs to conduct this specific training in their jurisdictions.

LRN Level B PHLs should describe how they will support and coordinate with local Level A PHLs in the catchment area to conduct training for Level A Clinical Laboratories, including use of a standard protocol for the collection, packaging and transport of human (blood, urine) or environmental samples for chemical agent analysis to a CDC or CDC-designated laboratory.

CDHS Activities (LRN Level A PHLs):

Facilitate development of a standard training protocol and materials for Level A laboratories; facilitate organization of multi-jurisdictional training seminars and workshops for Level A laboratory training.

Provide CDC/CDHS-sponsored proficiency evaluation methods

Provide CDC/CDHS-sponsored information on common data standards and electronic methods

Provide CDHS-contracted readiness assessment/gap analysis for laboratory safety and security.

CDHS Activities (LRN Level B PHLs):

Facilitate development of a standard protocol and training for LRN Level A laboratories (to be used in training by LRN Level B Laboratories.)

Hold quarterly or semi-annual meetings with Level B Laboratories.

Develop proficiency testing and other standards.

V. SUBMISSION #3: CATEGORY 2 AND 3: LHD BIOTERRORISM PREPAREDNESS PLAN: BUDGET REQUIREMENTS

A. GENERAL INSTRUCTIONS

Your application and plan must be accompanied by a budget using the required budget template. This budget is intended as a statement of your proposed expenditures and may be refined as you are able to better project local needs over time. The budget period for these funds will end June 30, 2003. The State-Local planning teams collaboratively prepared the California application and determined the level of funds being directed to LHDs in California by Focus Area. The following table indicates the **suggested** funding amounts available by Focus Area that were approved by CDC for local expenditure.

Category 2 Suggested Budget Priorities	
Focus Area A (Planning & Readiness Assessment)	32 Percent
Focus Area B (Surveillance & Epidemiology)	30 Percent
Focus Area C (Biologic Laboratory Capacity)	Funded Individually*
Focus Area D (Chemical Laboratory Capacity	Not Funded**
Focus Area E (Health Alert Network)	15 Percent
Focus Area F (Risk Communication)	8 Percent
Focus Area G (Education & Training)	15 Percent
*Separate funding is available for jurisdictions with a Public Health Laboratory via Category 3 funds. **CDC excluded funding for Chemical Laboratory Capacity from its award to the Department.	

Separate budgets will be required for each Focus Area. These must be submitted with each Focus Area narrative and must adhere to the Expenditure Report and Budget Templates in the Plan and Budget Appendix 1.

B. DEFINITIONS

These funds may not be used to **replace or supplant** current state or local expenditures. Specifically, note that these funds are not to be used to replace existing federal, state or local funds for bioterrorism, infectious disease outbreaks, other public health threats and emergencies, and public health infrastructure within the jurisdiction. They are to be used to augment current funding and focus on public health preparedness activities under CDHS' agreement with CDC.

All funds must be accounted for by Focus Area, including funds that are dispersed to other local agencies and contractors.

Carryover of unexpended funds means that funds from the current fiscal year that are unspent or unencumbered at the end of that fiscal year can be identified and then become available for expenditure in the next fiscal year, depending upon approval from CDHS (who must seek one-year carryover each year from the CDC). Carryover of unspent funds from one year to the next can be denied by CDC or they can be required to be used for a new project/activity. More recently, CDC's policies have been to approve carryover but to reduce the next year's funding by the amount of the carryover. LHDs should make every effort to spend all funds in the year for which they are allocated.

To encumber available funds means to burden your account (the Trust Fund) with legal or financial obligations that will be paid during the fiscal year or will be paid for services provided in the fiscal year. These funds, while technically still available in the account/Fund, are earmarked for future payment.

C. BUDGET AND JUSTIFICATION

Separate Budget Templates (Forms II-2 through II-6) are included in the Plan and Budget Appendix 1 to display proposed spending in Focus Areas A, B, E, F, and G. The Template and narrative should be included at the end of each Focus Area section.

Counties/City that maintain a public health laboratory should use Form II-7 (located in Plan and Budget Appendix 1) to display the costs they anticipate having for the Level A Statement of Work included the LRN Appendix 3. Level B PHLs should submit the budget negotiated with CDHS using the cost categories displayed in the form.

Specific Budget Narrative instructions are included in the Plan and Budget Appendix 1. Please note that while the budget templates do not itemize costs, each cost category must be itemized and justified in your narrative, using the instructions in the above Appendix 1.

APPENDIX 1

BUDGET TEMPLATES
NARRATIVE INSTRUCTIONS

PLAN AND BUDGET WORKSHEET FORM II-1

COUNTY _____

PUBLIC HEALTH PREPAREDNESS AND
RESPONSE TO BIOTERRORISM
FY 2002-03 WORKSHEET

BUDGET SUMMARY AMOUNTS TO BE INCLUDED IN THE PLAN AND BUDGET

CATEGORY 1 CARRYOVER	$
CATEGORY 2	$
CATEGORY 3	$
TOTAL*	$

Focus Areas	Suggested Budget Priorities	Proposed with Plan and Budget
A	$	$
B	$	$
E	$	$
F	$	$
G	$	$
C	$	$
TOTAL*		$

**** THE TOTAL AMOUNT AVAILABLE SHOULD EQUAL THE TOTAL PROPOSED BUDGET.***

PLAN AND BUDGET FORM II-2

COUNTY _____

PUBLIC HEALTH PREPAREDNESS AND RESPONSE TO BIOTERRORISM FY 2002-03 BUDGET

CATEGORY 1 CARRYOVER FUNDS AND CATEGORY 2 FUNDS

COST CATEGORIES FOR *FOCUS AREA A*	**AMOUNT**
A) Personnel	$
B) Fringe Benefits	$
C) Travel	$
D) Equipment	$
E) Operating Expenses & Supplies	$
F) Consultants	$
G) Contractual	$
H) Other	$
Total Direct Charges	$
I) Indirect Charges	$
TOTAL BUDGET FOR *FOCUS AREA A* (SUM OF CATEGORIES A-I)	$

PLAN AND BUDGET FORM II-3

COUNTY _____

PUBLIC HEALTH PREPAREDNESS AND RESPONSE TO BIOTERRORISM FY 2002-03 BUDGET

CATEGORY 1 CARRYOVER FUNDS AND CATEGORY 2 FUNDS

COST CATEGORIES FOR *FOCUS AREA B*	**AMOUNT**
A) Personnel	$
B) Fringe Benefits	$
C) Travel	$
D) Equipment	$
E) Operating Expenses & Supplies	$
F) Consultants	$
G) Contractual	$
H) Other	$
Total Direct Charges	$
I) Indirect Charges	$
TOTAL BUDGET FOR *FOCUS AREA B* (SUM OF CATEGORIES A-I)	$

PLAN AND BUDGET FORM II-4

COUNTY _____

PUBLIC HEALTH PREPAREDNESS AND RESPONSE TO BIOTERRORISM FY 2002-03 BUDGET

CATEGORY 1 CARRYOVER FUNDS AND CATEGORY 2 FUNDS

COST CATEGORIES FOR *FOCUS AREA E*	**AMOUNT**
A) Personnel	$
B) Fringe Benefits	$
C) Travel	$
D) Equipment	$
E) Operating Expenses & Supplies	$
F) Consultants	$
G) Contractual	$
H) Other	$
Total Direct Charges	$
I) Indirect Charges	$
TOTAL BUDGET FOR *FOCUS AREA E* (SUM OF CATEGORIES A-I)	$

PLAN AND BUDGET FORM II-5

COUNTY _____

PUBLIC HEALTH PREPAREDNESS AND RESPONSE TO BIOTERRORISM FY 2002-03 BUDGET

CATEGORY 1 CARRYOVER FUNDS AND CATEGORY 2 FUNDS

COST CATEGORIES FOR *FOCUS AREA F*	**AMOUNT**
A) Personnel	$
B) Fringe Benefits	$
C) Travel	$
D) Equipment	$
E) Operating Expenses & Supplies	$
F) Consultants	$
G) Contractual	$
H) Other	$
Total Direct Charges	$
I) Indirect Charges	$
TOTAL BUDGET FOR *FOCUS AREA F* (SUM OF CATEGORIES A-I)	$

PLAN AND BUDGET FORM II-6

COUNTY _____

PUBLIC HEALTH PREPAREDNESS AND RESPONSE TO BIOTERRORISM FY 2002-03 BUDGET

CATEGORY 1 CARRYOVER FUNDS AND CATEGORY 2 FUNDS

COST CATEGORIES FOR *FOCUS AREA G*	**AMOUNT**
A) Personnel	$
B) Fringe Benefits	$
C) Travel	$
D) Equipment	$
E) Operating Expenses & Supplies	$
F) Consultants	$
G) Contractual	$
H) Other	$
Total Direct Charges	$
I) Indirect Charges	$
TOTAL BUDGET FOR *FOCUS AREA G* (SUM OF CATEGORIES A-I)	$

PLAN AND BUDGET FORM II-7

COUNTY _____

PUBLIC HEALTH PREPAREDNESS AND RESPONSE TO BIOTERRORISM FY 2002-03 BUDGET

CATEGORY 1 CARRYOVER FUNDS AND CATEGORY 2 FUNDS

COST CATEGORIES FOR *FOCUS AREA C*	**AMOUNT**
A) Personnel	$
B) Fringe Benefits	$
C) Travel	$
D) Equipment	$
E) Operating Expenses & Supplies	$
F) Consultants	$
G) Contractual	$
H) Other	$
Total Direct Charges	$
I) Indirect Charges	$
TOTAL BUDGET FOR *FOCUS AREA C* (SUM OF CATEGORIES A-I)	$

BUDGET NARRATIVE

FUNDING CATEGORY:	**FOCUS AREA:**
PERSONNEL: PY	**TOTAL SALARIES: $**
Classification/Title For each position responsible for the activities in this focus area, describe the main duties. All positions identified in your plan as having primary responsibility for activities within the Focus Area must be listed. List the position descriptions, annual salary, percentage of time, and number of months. Calculate the total for the budget period. For Laboratory positions: All Laboratory Response Coordinator, Laboratory Training Coordinator, and Laboratory Liaison positions must be clearly identified. Personnel funds should be devoted to stipends for Public Health Microbiologist Interns to augment the number of trainees already supported from other state and local funds. Two alternatives are available. If funds are sufficient for one or more trainees, they can be administered locally if you desire. Otherwise, please consider assigning them to a central training account to be administered by the CDHS Laboratory Program Office under the supervision of the Assistant Deputy Director for Laboratory Science, CDHS. Funds may not be used to replace existing federal, state or local funds for bioterrorism, infectious disease outbreaks, or other public health threats or emergencies, and public health infrastructure within the jurisdiction. You may not claim reimbursement costs for existing locally supported personnel involved in Bioterrorism Preparedness/Response or Public Health Emergency Response activities.	
FRINGE BENEFITS (% of salaries)	**$**
TRAVEL	**$**
In-State Travel: Description, type, and cost of travel staff will be taking (meetings, trainings, conferences), number of staff, and number of trips. Please budget for 4 trips for one person to Sacramento/San Francisco for the budget period. Attach LHD standard costs if these were used to calculate travel costs. Other Travel: Out-of-state travel is subject to approval by CDHS. Provide a justification for any trips planned across the U.S.- Mexico Border or out of California. Training (Travel Costs): This should primarily support Level A and First Responder training efforts. List expenses for travel associated with training activities (number of personnel, estimated costs for mileage or air fare and per diem at standard county or state rates, including (1) sending staff to assist in one each regional Level A and First Responder training seminar/workshop; (2) Sending your laboratory staff for in-state training that will enhance LRN Level B laboratory skills; (3) Travel for Public Health Microbiologist Interns living locally in your jurisdiction and supported by your laboratory to attend required training modules provided by Public Health Laboratories in California but outside your jurisdiction.	

BUDGET NARRATIVE (continued)

EQUIPMENT		**$**
Equipment is defined as durable items costing more than $5,000. Describe equipment that will be purchased, its total cost including tax, shipping and any installation charges. Justify each item by stating the LRN, bioterrorism, or public health emergency preparedness or response activity it will be used for. Explain the benefit, and cost for each item. State where the equipment will be located within the jurisdiction (in office, satellite location, etc.).		
OPERATING EXPENSES & SUPPLIES		**$**
General Expense	$	
Printing	**$**	
Telephone	**$**	
Rent	**$**	
Training	**$**	
Postage	**$**	
Other	**$**	

Supplies for LRN B Laboratories: List general categories: These should include (1) Light Cycler and TRF supplies/reagents; (2) Supplies associated with LRN Level B laboratory preparedness and Public Health Emergency Response; (3) Supplies/reagents needed to assure Surge Capacity; (4) Supplies/reagents for Level A laboratory and First Responder training, including one regional training seminar/workshop and individual training of Clinical or Public Health laboratories (if these will be done-estimate the number to be trained); (5) If you train additional Public Health Microbiologist Interns in-house over what you already have planned, you may claim supply costs related to the additional Public Health Microbiologist training.

Supplies for LRN A Laboratories: Supplies must be consistent with the needs of a Level A Public Health Laboratory. List general categories: (1) Supplies associated with LRN Level A laboratory preparedness and public health emergency response; (2) supplies needed to assure surge capacity; (4) training supplies and (5) other (which must be described).

Training (Other Costs): Costs associated with training activities other than travel and supplies or reagents. These can include durable items costing less than $5,000 (i.e., multimedia projector, laptop or desktop computer with software, waterbaths, other small laboratory items, etc.) registration materials, rental of workshop or conference facilities, etc.).

BUDGET NARRATIVE (continued)

CONSULTANTS	**$**
Name of consultant, term of contract, deliverables from consultant, what will they be doing to benefit the county/city, total cost. One line item per contract.	
CONTRACTUAL	**$**
Name of contractor/sub-contractor/contract, term of contract, deliverables from contractor, what will they be doing to benefit the county/city, cost. For all Contracts, CDC will require the following: (1) Name of Contractor; (2) Method of Selection; (3) Period of Performance; (4) Detailed Scope of Work; (5) Method of Accountability; and (6) Itemized Budget and Justification for each item. The Scope of Work should include a description of the deliverable, why it is needed and how it will be used. One line item per contract.	
OTHER	**$**
This category would include rent, if charged, or other costs not included elsewhere. These costs should be itemized and explained.	
INDIRECT COSTS	**$**
A maximum of 10 percent of total Personal Services costs (Personnel + Fringe Benefits) is allowed to cover indirect administration costs.	
TOTAL REQUEST FOR FOCUS AREA	**$**
Reminder: You may only budget contracts and consultants through June 30, 2003, which is the term of the Application and Agreement.	

VI. SUBMISSION #4: EMERGENCY PREPAREDNESS AND RESPONSE CAPACITY INVENTORY

Please submit one completed copy (hardcopy) version of this inventory with completed Plan and Budget submission. If you are submitting your Plan and Budget electronically, please submit a completed hardcopy version with your original signature pages. An electronic version of this Inventory is available as a PDF file at: http://www.dhs.ca.gov/epo.

VII. SUBMISSION #5: CERTIFICATION OF ACTIVITIES AND USE OF FUNDS

CDHS will require certification by the Chairperson of the County Board of Supervisors or the Mayor of a City that the proposed activities and budgets will not supplant existing levels of public health activity or funding within the jurisdiction.

This Certification applies to all Categories of available FY 2002-03 Funding and must be submitted with your Plan and Budget on or before October 15, 2002. Any Plan and Budgets submitted without the Certification Form will not be reviewed by CDHS and may initiate recoupment of FY 2002-03 quarterly payments made to the jurisdiction.

A copy of this Certification Form is enclosed as Plan and Budget Form III-1.

CERTIFICATION FORM III-1

PUBLIC HEALTH PREPAREDNESS AND RESPONSE TO BIOTERRORISM FISCAL YEAR 2002-03

_____

(County/City and Name of Local Health Department)

I hereby certify that the above-named local health department shall not use funds allocated by the California Department of Health Services to supplant funding for existing levels of service and that funds shall only be used for the purposes specified in the local health department's Bioterrorism Preparedness Plan and approved by the California Department of Health Services.

I further certify that funds received shall be deposited in a Local Public Health Preparedness Trust Fund and expended only for the purposes stated in the local health department's Bioterrorism Preparedness Plan and Budget, and approved by the California Department of Health Services.

Chairperson, Board of Supervisors or the Mayor of a City

Signature:
Printed Name:
Title:
Phone:
Date:

Please return the original certification with your Plan and Budget to:

California Department Health Services
Emergency Preparedness Office
Attn: LHD Allocation Award Program
601 North 7th Street, M.S. 244
P.O. Box 942732
Sacramento, CA 94234-7320

VI. CHECKLIST

To assist you in developing a complete submission, please review your submission to be sure you have included the following:

Submission #1: Category 1 Report

- ✓ Narrative Report
- ✓ Expenditure Report (Form I-1)
- ✓ Close of Contract (Form I-2)

Submission #2 Category 2 Plan

- ✓ Completed Plan and Budget Worksheet (Form II-1)
- ✓ Narrative Proposal for each Critical Capacity listed for Focus Areas A, B, E, F, and G
- ✓ Narrative Proposal for the Critical Capacity listed for Focus Area C (if applicable)
- ✓ A One-Page Benchmark(s) Included With Each Focus Area Narrative
- ✓ Organized According to Instructions on Page 9

Submission #3 Category 2 Budget and Justification

- ✓ A Proposed Budget for Each Focus Area (Forms II-2 through II-7)
- ✓ A Narrative Justification for Each Budget

Submission #4 Emergency Preparedness and Response Capacity Inventory

- ✓ A Completed Hard Copy of a Capacity Inventory for the LHD

Submission #5 Certification Form

- ✓ A Signed Certification Form (Form III-1)

APPENDIX 2

LABORATORY RESPONSE NETWORK
PUBLIC HEALTH LABORATORY
WORK STATEMENTS

LABORATORY RESPONSE NETWORK (LRN)
LEVEL A PUBLIC HEALTH LABORATORY
WORK STATEMENT

1. **LRN Level A Laboratory Procedures.** The PHL agrees to incorporate, maintain current and validate for use all available "Level A Laboratory Procedures for Identification of Various Agents" ("rule-out or refer") as posted on the Centers for Disease Control and Prevention Website at http://www.bt.cdc.gov/LabIssues/index.asp and any other protocols; e.g., procedures for sampling and analysis of environmental surfaces, water, food, etc. that may be required for "rule-out or refer" testing as may from time to time be made available directly by CDC or by the State's Microbial Diseases Laboratory (MDL). The PHL agrees to provide a semi-annual report to the State's MDL of validated LRN Level A laboratory procedures currently in place, identifying any updated procedures adopted and validated since the last report.

   NOTE: In addition to the above, Imperial County will coordinate to arrange for translation of the CDC website materials into Spanish for reference by sister-city laboratories.

2. **Enhanced Statewide Public Health Microbiologist training.** California currently suffers from an acute shortage of Certified Public Health Microbiologists. Level A PHLs that are CDHS Laboratory Field Services (LFS)-approved for training in one or more specified areas agree to participate in the training of LFS-approved trainees in procedures required for certification as a California Public Health Microbiologist. Jurisdictions that are not LFS approved for training can elect to support trainees directly, or may identify a portion of their allotment to be retained in a Public Health Microbiologist training account to be established and administered by the DHS Laboratory Program Office for training public health microbiologists.

3. **Training in LRN Level A Laboratory Procedures.** To assure that proficiency in the use of these methods is acquired, maintained and documented, the PHL agrees to participate in Level A laboratory training and exercises. The PHL agrees to ensure internal and external proficiency testing to include CDC and/or State-sponsored proficiency evaluation of Level A LRN standard protocols when available. The PHL also agrees to provide to the State's MDL a semi-annual report of training received and exercises completed.

   NOTE: Imperial County will sponsor/organize such training as appropriate for neighboring Mexico laboratories in collaboration with Baja California and Mexico health authorities.

4. **Clinical Laboratory Outreach.** The PHL agrees to work with its assigned Level B PHL to establish and maintain contact with local clinical microbiology laboratories in support of a coordinated response to bioterrorism, outbreaks of infectious disease or other public health threats and emergencies. The PHL will identify an individual to be the lead person to serve as the primary point of contact and liaison between the PHL and clinical microbiology laboratories in its jurisdiction and with the PHL's assigned Level B laboratory. The PHL will provide copies of current CDC Level A laboratory Procedures as described above to the clinical laboratories, assure that copies of the current California Laboratory Disease Reporting regulations are provided to clinical laboratories (Title 17, Section 2505, et. seq.) and assure that clinical laboratories are familiar with current enhanced disease reporting requirements. The PHL also will assure that clinical laboratories are informed of training opportunities for LRN Level A Procedures and other LRN training opportunities. The PHL will acquire and maintain a list of contact numbers for key clinical microbiology laboratory personnel (i.e., laboratory director,

Microbiology Supervisor, Bioterrorism coordinator, etc.) for each clinical laboratory in the jurisdiction. Contact numbers for the clinical laboratories should include 24-hour, 7 day-per-week telephone, pager, and e-mail information, as available that must be updated as often as needed to assure accuracy. These contact lists and any updates must be shared with the PHL's assigned Level B laboratory and with the State's Microbial Diseases Laboratory. ***Critical Benchmark #10***

NOTE: Documentation for this benchmark is a one-page timeline of key activities.

NOTE: Imperial County will provide copies of current CDC Level A laboratory procedures to appropriate neighboring Mexico clinical laboratories, assure laboratory staff are familiar with current enhanced disease reporting requirements, and inform them of pertinent training opportunities for Level A procedures.

5. **LRN Level A Clinical Laboratory Training.** To the extent possible, training for clinical laboratories in Level A LRN procedures and requirements will be a statewide, jointly planned and conducted effort. Multi-jurisdictional workshops and seminars together with distance-learning or internet-based training will be employed as feasible. Level A PHLs agree to assist when requested in planning, conducting and supporting multi-jurisdictional training efforts that include clinical laboratories and personnel in their jurisdictions. Level A PHLs are also encouraged to conduct independent intra-jurisdictional Level A clinical laboratory training that the jurisdiction considers as necessary and practical. Training provided independently should be consistent with statewide training efforts. If independent training is done, the PHL will provide the State's MDL with a semi-annual report describing the dates when training was provided, the training provided and the laboratories/persons trained.

   NOTE: Imperial County is encouraged to conduct independent cross-border Level A clinical training as appropriate and necessary.

6. **LRN Level A Laboratory and First Responder Cross-Training in safe specimen handling.** The level A PHL agrees to participate with HAZMAT personnel, Level B PHLs and the State laboratory to develop courses for cross-training of "First Responders" in specimen intake and handling for microbiological analysis, and in training of laboratory personnel in methods to evaluate intake samples for chemical, radiological, and explosive risk. Training will be conducted locally and will be coordinated as practical with statewide efforts employing multi-jurisdictional training seminars and workshops as well as distance-learning strategies. The Level A PHL agrees to assist and participate in the planning, support and conduct of these training efforts. Level A PHLs are encouraged to conduct such independent intra-jurisdictional training activities, as they may consider as necessary and practical. A semiannual report of cross-training training activities will be provided to the State's MDL.

7. **Outreach and Joint Training in Proper Specimen Packaging and Transport for Clinical laboratories, Law Enforcement Personnel and Other First Responders.** (a). Following completion of training in specimen packaging and transport requirements, the local PHL will consult with its assigned Level B laboratory to identify the required specimen types, amounts, and condition for each Level B assay, together with required information (Patient identification, provider identification, specimen or culture type and source, clinical condition, clinical findings, etc.) and proper packaging requirements, and appropriate transport requirements and preferred carrier for the specimen or culture to be transported and the assay requested). (b) Training efforts will include participation in state-sponsored training of local public health and clinical laboratory staff in packaging of human specimens intended for chemical threat agent analysis. (c) The PHL will establish a protocol that encourages/requires clinical microbiology laboratories to consult with the PHL regarding the above specimen or culture, packaging and transport requirements for LRN B or higher laboratory referrals to assure that the clinical

laboratory or "first responder" has collected a specimen/culture of the proper kind, condition, and amount required for Level B or higher testing. The PHL also will assist in determining the appropriateness and completeness of required information and will assist as needed to supply an appropriate specimen collection and transport kit (kit supply provided to the PHL by the State's MDL or VRDL in the usual manner). The PHL also will be prepared to assist in identifying an appropriate transport carrier (courier or common carrier, etc. as preferred by the Level B or higher laboratory or Law Enforcement Officials, as appropriate.)

8. **Participation in development and implementation of an integrated response plan.** The PHL agrees to participate with the assigned Level B PHL, the State PHL and others (i.e., EPO, etc.,) as required to develop an integrated response plan that directs how laboratories at the local level will respond to a bioterrorism incident including: (a) roles and responsibilities; (b) inter- and intra-jurisdictional surge capacity; (c) how the plan integrates with other local emergency response efforts; (d) integrates protocols for safe transport of specimens by air and ground; and (e) how lab results will be shared with state and other local public health and law enforcement agencies. The local plan must be consistent with statewide standards and requirements for disease reporting and coordinated emergency responses.

   NOTE: Imperial County's plan should be an integrated bi-national response plan for how laboratories at the local level in both countries will respond.

9. **Threat Specimen Tracking and Workload Balancing (Surge Capacity and Specimen Triage).** The PHL agrees to assist in efforts to determine statewide base and surge testing capacities. In addition, whenever requests for Level A testing are received, or if a culture is identified as a possible Bioterrorism Threat Agent as defined by CDC (see definitions on the CDC Website at http://www.bt.cdc.gov/Agent/Agentlist.asp) the assigned Level B laboratory and the State's MDL will be notified immediately and kept informed of the current Level A and total workload at least daily until processing of all threat agents on hand in the laboratory is complete.

10. **Participation in Efforts to Enhance Electronic Communications within the LRN.** The PHL agrees, as possible and practical, to participate in state-sponsored efforts to develop common data standards and electronic methods to (a) monitor network capacity to process and analyze specimens; (b) perform sentinel surveillance; (c) support proficiency testing and multi-center validation studies for new methods; (d) develop high-speed internet and network connectivity needed to access LRN protocols, reagents and lab user applications.

11. **State-Sponsored Readiness Assessments.** The Level A PHL agrees to participate in state-contracted readiness assessments and gap analyses of (a) current laboratory safety and security; (b) operational plans and protocols for identification of threat agents; (c) electronic communication capabilities and electronic data network security. The results of the assessments will be provided to the Level A laboratory for its use in planning, etc., and will be included in summary form in the State's report to CDC describing its current readiness state.

    NOTE: Imperial County will also participate in a state-contracted readiness assessment and gap analysis that addresses binational laboratory capacity and coordination.

12. **Approval for Equipment purchased through project funds.** With the approval of the State's MDL, a portion of the Level A training and support funds may be used to purchase equipment required to permit conduct of Level A Laboratory Procedures for "Identification of Various Agents" as described in 1 above, or to improve the capacity to conduct Level A analyses or that may be required to participate in Level A clinical laboratory training and outreach.

LABORATORY RESPONSE NETWORK (LRN)
LEVEL B PUBLIC HEALTH LABORATORY
WORK STATEMENT

A. Develop and implement a local program to ensure rapid and effective laboratory services in support of the response to bioterrorism and other infectious disease outbreaks, public health threats and emergencies.

1. Prepare a timeline for the development of a plan to improve relationships and communications between the local health jurisdiction and Level A (clinical) laboratories and Level B/C public health laboratories. The plan should ensure that Level A clinical and public health laboratories maintain core capability to: a) perform rule-out testing on critical BT agents; b) safely package and handle specimens; c) refer to higher level laboratories for further testing; and d) assure that clinical laboratories understand and comply with local jurisdiction and statewide reporting requirements and procedures. The local training plan for level A clinical laboratories must be coordinated with and supportive of multi-jurisdictional state training plans for level A laboratories and must stress the incorporation and use of CDC Laboratory Response Network (LRN)-approved Level A laboratory testing procedures.

   Critical Benchmark #10: **Documentation of this benchmark is a one-page timeline of key activities for plan development that identifies key staff.**

   NOTE: San Diego County's plan should include neighboring Baja California jurisdictions.

2. Coordinate with other local public health laboratories and with the state laboratory to develop an integrated, catchment-wide, response plan that directs how laboratories at the local level will respond to a bioterrorism incident including: a) roles and responsibilities, b) inter- and intra-jurisdictional surge capacity, c) how the plan integrates with other local emergency response efforts, d) protocols for safe transport of specimens by air and ground, and e) how lab results will be reported and shared with state and other local public health and law enforcement agencies. The plan must be consistent with statewide standards and requirements for disease reporting and coordinated emergency responses.

   NOTE: San Diego County's coordination with other local PHLs should include those in Mexico.

3. Cooperate with the State Laboratories to: (a) develop a standard protocol and provide training to local Level A laboratories for tracking and safe handling, packaging, and transport to CDC-designated laboratories of chemical agents that might be present in human blood and urine samples; (b) enhance statewide public health microbiologist training. Level B PHLs that are LFS approved for training in one or more specified areas agree to participate in the training of LFS-approved trainees in procedures required for certification as a California Public Health Microbiologist. Jurisdictions that are not LFS approved for training can elect to support trainees directly, or may identify a portion of their allotment to be retained in a Public Health Microbiologist training account to be established and administered by the DHS Laboratory Program Office for training public health microbiologists.

B. As a member of the Laboratory Response Network (LRN), and as reasonably possible, work to ensure adequate and secure laboratory facilities, reagents, and equipment to rapidly detect and correctly identify biological agents likely to be used in a bioterrorist incident.

1. Develop and implement operational plans and protocols that:

   Address issues relating to specimen/sample transport and handling.

   Include the development and implementation of a triage procedure for prioritizing intake and testing of specimens/samples before analysis.

   Fully address worker safety.

   Ensure appropriate Bio-Safety Level (BSL) working conditions.

   Provide for appropriate and adequate staffing and training of personnel.

   Address quality control and assurance (adherence to and validation of laboratory methods and protocols).

   Ensure internal and external proficiency testing to include CDC- and State-sponsored proficiency evaluation of Level A and Level B LRN standard protocols.

   Ensure secure storage of critical agents.

   Assess the level of supplies and equipment needed to respond to a disease outbreak or bioterrorism event.

   Ensure appropriate levels of supplies and equipment is available, with a strong emphasis on surge capacities needed to effectively respond to a bioterrorism incident.

   Cooperate with and participate in a State-sponsored assessment and gap analysis of the above local capabilities.

2. Ensure consistent laboratory security by:

   Utilizing Bio-safety in Microbiological and Biomedical Laboratories, 4th Edition" (BMBL) Guidelines for local laboratory security.

   Enhancing local lab security as needed through use of video surveillance, perimeter security, and screening for radiological, explosive, and chemical risk of specimens prior to biologic analysis.

   Cooperating with and participate in a State-sponsored assessment and gap analysis of the above local capabilities.

3. Serve as a regional reference center for the isolation and identification of bioterrorism (BT) threat agents in their catchment areas in California as specified by the CDHS in support of the LRN. These agents include, but are not exclusive to, *Bacillus anthracis, Yersinia pestis, Francisella tularensis*, and *Brucella* species. Laboratories shall acquire and achieve proficiency in the use of such other LRN protocols as may from time to time become available. Such diagnostic activities include, but are not exclusive to, conventional LRN-specified isolation and identification procedures. Procedures include detection of BT agents by fluorescent antibody methods, LRN-specified rapid molecular identification procedures utilizing "real-time" PCR assays (LightCycler or equivalent) and LRN-specified

time-resolved fluorescence (TRF) assays using the Victor^2 system according to established LRN protocols.

4. Assist as requested in planning and conducting state-sponsored multi-jurisdictional training seminars and workshops involving their catchment area. Provide Level A clinical laboratory training within the jurisdiction and assist Level A public health laboratories in their catchment area with training activities as follows:

   (a) Training of all Level A clinical laboratories within their jurisdictions and Level A public health laboratories in their catchments in CDC LRN Level A laboratory protocols regarding specimen collection, isolation and rule-out testing procedures for BT agents and proper packaging, local and statewide procedures for notification and transfer of suspect BT cultures to their appropriate regional Level B laboratory for reference identification;

   (b) Assist as requested in training of newly designated LRN Level B laboratory staff in fundamental CDC LRN Level B protocols regarding the isolation and identification of BT agents as specified by the State Level C coordinator(s); and

   (c) Conduct training and support local Level A PHLs within the catchment area in the training of clinical Level A laboratories in a standard protocol for the collection, packaging and transport of human (blood, urine) or environmental samples for chemical agent analyses to CDC or a CDC-designated laboratory.

   NOTE: San Diego County should assist in planning/conducting cross-border training seminars and workshops, as requested. It should include neighboring Mexico laboratories in training activities listed in (a) and (c) above.

5. Participate in quarterly or semi-annual regional meetings with the Level C laboratories regarding current LRN issues including planning and coordination of response and reporting protocols, training activities, safety and security, newly developed Level A and Level B laboratory testing protocols, electronic laboratory reporting and surveillance data system development and implementation, and epidemiologic issues, etc. Provide the state Level C laboratory with reasonable data requests in a prompt and timely fashion concerning sample triage and testing, lab results, training and coordination activities within their jurisdiction with major partners including Level A laboratories, federal, state, and local law enforcement agencies, and allied public health care responders.

   NOTE: San Diego County should make a recommendation regarding participation of an appropriate Baja California representative for quarterly or semi-annual meetings and include cross-border laboratories in their coordination with Level C laboratory procedures.

6. Participate in at least one BT tabletop simulation exercise during the calendar year that assesses laboratory readiness to respond to a BT threat agent as listed above. Simulation and co-planning may involve one or more of the following:

   Participate in CDC- and State-sponsored proficiency testing exercises to evaluate capability in LRN Level B testing procedures to identify BT threat agents.

   Establish operational relationships with local members of HAZMAT response teams, additional first-line responders, and regional FBI centers.

   Cross-train personnel in each discipline.

Establish designated points of contact within these groups.

Jointly sponsor conferences and workshops.

7. Develop enhanced community-based relationships with local medical centers, infectious disease practitioners, universities, and other allied public health and medical staff regarding outreach training sessions, workshops, conferences, and infectious disease public health grand rounds.

   NOTE: San Diego County outreach should include cross-border relationships.

8. Participate in DHS-sponsored developmental electronic communication systems to provide rapid communication, coordination, and response efforts to real or perceived BT threats between state and local agencies. Cooperate with and participate in a State-sponsored assessment and gap analysis of local electronic communication capabilities and electronic data network security. Participate in State-sponsored efforts to develop common data standards to facilitate intergovernmental emergency communications.

   NOTE: San Diego County should extend its assessment and gap analysis to include cross-border electronic communication capabilities.

9. ***NOTE: San Diego County will identify and fund (at least part-time) a staff person to act as a border laboratory contact person and to conduct cross-border laboratory training/planning activities.***

10. ***NOTE: San Diego County will coordinate with and assist Imperial County in the implementation of border laboratory training and planning activities.***